Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

JUVENILE REHABILITATION ADMINISTRATION (JRA)

# YOUTH SUICIDE RISK ASSESSMENT

- ☐ Intake
- ☐ Warning Sign(s) or Other Indicator
- ☐ SPL Review
  - ☐ Increase
  - ☐ Reduction
  - ☐ No change

**Part I: Youth Information**

| YOUTH'S NAME: LAST FIRST MIDDLE | JRA NUMBER | DATE OF BIRTH | SEX ☐ Male ☐ Female |
|---|---|---|---|
| | | | |

INFORMATION SOURCE(S)

| NAME OF STAFF COMPLETING ASSESSMENT (PLEASE PRINT) | ASSESSMENT DATE |
|---|---|
| | |

| | YES | NO | |
|---|---|---|---|
| 1. Have you been sadder than usual? | ☐ | ☐ | If yes, for how long: _____ |
| 2. Have you been more irritable than usual? | ☐ | ☐ | If yes, for how long: _____ |
| 3. Have you been thinking of killing yourself? | ☐ | ☐ | If yes, for how long: _____ |
| 4. Have you thought about how you would kill yourself? | ☐ | ☐ | If no, go to question 8 below. |

5. What were you thinking of doing to kill yourself?
   - ☐ Pills/Overdose ☐ Cut Wrist
   - ☐ Hanging ☐ Jumping
   - ☐ Gun ☐ Other: _____

| | | | |
|---|---|---|---|
| 6. Do you have, or could you get, what you need to kill yourself? | ☐ | ☐ | |

7. When were you thinking of killing yourself?

| | | | |
|---|---|---|---|
| 8. Have you been hearing voices that are telling you to kill yourself? | ☐ | ☐ | |
| 9. Have you thought about killing yourself before this time? | ☐ | ☐ | If yes, when: _____ |
| 10. Have you ever tried to kill yourself? If no, go to question 12 below. | ☐ | ☐ | If yes, when: _____ |
| | | | If yes, how: _____ |

11. What happened after you tried to kill yourself (i.e., medical attention, interventions, outcomes)?

| | | | |
|---|---|---|---|
| 12. Has anyone in your family committed suicide? | ☐ | ☐ | If yes, who: _____ |
| 13. Has anyone close to you died recently? | ☐ | ☐ | If yes, who: _____ |
| 14. Have you had something bad or stressful happen to you lately? | ☐ | ☐ | If yes, what: |

| | | | |
|---|---|---|---|
| 15. If you have thoughts of killing yourself, would you be able to talk to a staff member about it? | ☐ | ☐ | If yes, who: _____ |
| 16. Will you make a commitment to tell staff if you feel like harming or killing yourself? | ☐ | ☐ | |
| 17. Do you currently take medication to treat mental health issues? | ☐ | ☐ | |
| 18. Have you taken your medications regularly in the past month? | ☐ | ☐ | |

**Part II: Staff Observations**

| | YES | NO | |
|---|---|---|---|
| 19. Has youth made statement(s) about wanting to die? | ☐ | ☐ | |
| 20. Has youth made statement(s) about wanting to kill self? | ☐ | ☐ | If yes: When: _____ |
| 21. Has youth demonstrated increased withdrawal or isolation? | ☐ | ☐ | If yes: For how long: _____ |
| 22. Has youth expressed feelings of hopelessness or depression? | ☐ | ☐ | |
| 23. Has youth reported experiencing hallucinations in which he/she was told to kill self? | ☐ | ☐ | |
| 24. Has youth demonstrated a marked change in performance of daily living activities? | ☐ | ☐ | |
| 25. Has youth demonstrated other warning signs? | ☐ | ☐ | If yes: What: |
| 26. Is youth currently prescribed psychotropic medication? | ☐ | ☐ | |
| 27. Has the youth demonstrated compliance in taking his medications during the last two weeks? | ☐ | ☐ | |
| 28. Does the youth carry a current DSM-IV diagnosis? | ☐ | ☐ | If yes: What: |

**Part III: Additional Staff Comments/Observations**

Use this space for comments or observations relevant to the assessment of a youth's risk for suicide and/or self-harm. (Include file search information regarding past suicide or mental health issues if this is the INITIAL SRA.)

**Notification:**

☐ Nurse or Designated Mental Health Professional

Who: _____ Time: _____ Date: _____

☐ Officer of the Day (OD) or Program Administrator

Who: _____ Time: _____ Date: _____

☐ Parent/Legal Guardian

Who: _____ Time: _____ Date: _____

**Part IV: Suicide Precaution Level Recommendation**

**Staff Name:**

_____

Requires Suicide Precaution Level:
☐ Yes
☐ No

**Designated Mental Health Professional Name:**

_____

Authorized Suicide Precaution Level:
☐ Level 1
☐ Level 2
☐ Level 3
☐ Level 4
☐ No Level Recommended

Copies to: JRA Designated Mental Health Professional
Youth's Supervision Unit
Youth's Case Manager
Youth's Legal File
Youth's Medical File